DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 7/08/12

PRINTED: 05/31/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445478	A. BUILDING _____ B. WING _____	05/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM-HENSLEY HEALTH AND REHABILITATION	65 NURSING HOME RD CHUCKEY, TN 37641

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	Disclaimer for Plan of Correction Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by Durham-Hensley Health & Rehabilitation of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. Durham-Hensley Health & Rehabilitation files this Plan of Correction solely because it is required to do so for continued state licensure as a health care provider and/or for participation in the Medicare/Medicaid program. The facility does not admit that any deficiency existed prior to, at the time of, or after the survey. The facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal and any other applicable legal or administrative proceedings. This Plan of Correction should not be taken as establishing any standard of care, and the facility submits that the actions taken by or in response to the survey findings far exceed the standard of care. This document is not intended to waive any defense, legal or equitable, in administrative, civil or criminal proceedings. F 272 Durham-Hensley Health & Rehabilitation believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Asst. Administrator 6/8/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 272	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to complete an assessment for a restraint prior to initiating for one resident (#40) of thirty-six residents reviewed in the Stage 2 sample. The findings included: Resident #40 was admitted to the facility with diagnosis including Anxiety, Cerebral Vascular Accident, and Abnormal Gait. Medical record review of a Physician Telephone Order dated March 8, 2012, revealed "...received order to have pelvic positioning padded thigh straps while up in...chair..." Interview and medical record review with the Minimum Data Set (MDS) Coordinator on May 23, 2012, at 4:08 p.m., of the resident's care plan updated March 8, 2012, revealed "...pelvic positioning padded thigh straps while in...chair..." Interview with the Director of Nursing (DON) in the DON office on May 24, 2012, at 7:51 a.m., confirmed Resident #40 did not have an assessment completed prior to starting a new restraint.	F 272	Corrective Actions for Targeted Residents Resident #40 was assessed by the Charge Nurse and Director of Nursing on 6/3/12 and determined that this is an appropriate device for this resident. Identification of Other Residents with Potential to be Affected Residents with restraining devices were audited by the Charge Nurse and RN Supervisor on 6/3/12 for pre-restraining assessments to ensure they had been completed. All current residents with a restraining device have a pre-restraining assessment in the medical record. Systematic Changes An in-service will be held for the licensed staff on 6/19/12 and 6/20/12 by the DON to educate staff that when they receive an order by the MD for a restraining device, a pre-restraining assessment must be completed. Any new admissions that enter the facility with orders for a restraining device must have a pre-restraining assessment completed. The interdisciplinary team will review this assessment to determine if the ordered device is appropriate. Monitoring The Director of Nursing will perform monthly audits of restraining devices for three months to ensure compliance. The results of the audit will be reported to the Performance Improvement Committee monthly for review and determination of ongoing compliance. This Committee	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	F 279		

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F 279	Continued From page 2 The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and interview the facility failed to complete a care plan to address the dental concerns for one resident (#12) of thirty-six residents reviewed in the Stage 2 sample. The findings included: Observation on May 21, 2012, at 9:00 a.m., revealed the resident sitting in a wheelchair listening to music. Continued observation and interview revealed the resident had several teeth missing with a tooth recently broken off that causes no pain. Medical record review of a Social Services note dated January 31, 2012, revealed "...resident	F 279	consists of the Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Medical Records Director, Maintenance Director, Social Services Director, Dietary Manager, Housekeeping/ Laundry Director, Activities Director, Business Office Manager, HR Manager, Medical Director and Consultant Pharmacist. F 279 Durham-Hensley Health & Rehabilitation believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions: Corrective Actions for Targeted Residents The care plan for Resident #12 has been updated to reflect dental needs. Identification of Other Residents with Potential to be Affected The Social Service Director performed an audit on 6/6/12 of current residents with any reported dental concerns to ensure a care plan is in place to reflect dental needs. Care plans regarding dental needs are current. Systematic Changes An in-service will be held for licensed staff on 6/19/12 and 6/20/12 to educate staff to report any dental concerns to the MD and Social Service Director. The Social	6/30/12

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F 279	Continued From page 3 seen by...dental and dental services unable to repair broken tooth that had broken off and recommended a partial...family notified and resident on list to be seen by...dental on next visit..." Interview with the Social Services Director on May 22, 2012, at 3:09 p.m., revealed the resident's family had been contacted and wished the resident to be seen on the next in house dental visit if no pain to resident. Interview and medical record review of the resident plan of care with the Minimum Data Set (MDS) coordinator on May 23, 2012, at 2:00 p.m., confirmed the care plan did not address the resident's dental needs.	F 279	Service Director will ensure services are received as ordered by the MD for any resident with dental concerns and will develop/revise the care plan. The MDS Coordinator will perform assessments on all newly admitted residents and develop a care plan based on assessment findings. These assessments will also be repeated quarterly and care plans will be updated accordingly by the MDS Coordinator. Monitoring The Social Service Director will perform audits for three months to ensure care plans are in place for residents with dental needs. Results of the audits will be reported to the Performance Improvement Committee for review and determination of ongoing compliance. The Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Medical Records Director, Maintenance Director, Social Services Director, Dietary Manager, Housekeeping/Laundry Director, Activities Director, Business Office Manager, HR Manager, Medical Director and Consultant Pharmacist.	6/30/12
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to provide restorative services for one resident (#37) of thirty-six of residents reviewed of the stage two sample. The findings included: Resident #37 was admitted to the facility on December 7, 2011, with diagnoses including Hypertension, Dementia, Depresssion and Arthritis.	F 311	F 311 Durham-Hensley Health & Rehabilitation believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:	

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F 311	Continued From page 4 Medical record review of a Physician's Order dated March 5, 2012, revealed "restorative therapy for AROM (active range of motion) to BUE (bilateral upper extremities) 3 X wk X 4 wk (three times a week for 4 weeks)." Review of the Restorative Nursing documentation tool for March 2012, revealed the resident was to have received twelve (12) restorative sessions for the months of March and April. Continued review of the documentation revealed the resident received seven (7) treatments in March and six (6) treatments in April 2012. Interview with the Restorative Aid on May 24, 2012, at 10:34 a.m., at the Hensley wing nurses' station, confirmed the documentation revealed the resident only received seven (7) treatments for March, six (6) treatments for April, and verified the resident was to have received twelve (12) treatments each month. Further interview revealed the resident continues to be on restorative therapy.	F 311	Corrective Actions for Targeted Residents Resident #37 was assessed by the rehabilitation department on 6/4/12 and was found to have no decline in any ADL functioning as a result of not receiving restorative services at the frequency ordered. Resident #37 is currently receiving restorative services three times per week as ordered. Identification of Other Residents with Potential to be Affected An audit was performed by the Assistant Director of Nursing on 6/7/12 of documentation of current residents with orders for restorative services. Documentation for residents with orders for restorative services are compliant. Systematic Changes The restorative program has been reorganized and is being supervised by the Assistant Director of Nursing in conjunction with the Director of Therapy Services. The ADON is communicating daily with the restorative aides to ensure services are being delivered as ordered. An in-service for staff is being held on 6/19/12 and 6/20/12 to educate staff on the reorganization of the restorative program. Monitoring The Assistant Director of Nursing will perform weekly audits for three months of restorative services provided and completion of documentation. The results of	
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a	F 325		

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F 325	Continued From page 5 nutritional problem. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to make timely interventions to prevent weight loss causing a delay in treatment for one (#53) of thirty-six residents reviewed in the stage 2 sample. The findings included: Resident #53 was admitted to the facility on September 4, 2011, with diagnoses including Dementia, Diabetes, Anxiety, Depression, and Atrial Fibrillation. Medical record review revealed the resident had no cognitive impairment and required only occasional assistance with activities of daily living. Review of the resident's plan of care dated September 21, 2011, revealed problem of "potential for weight loss," with interventions of "...offer small portions of desired foods, low fat, low cholesterol, chopped meat diet, encourage high calorie snacks, provide assistance during meals with set-up and cueing...Resident able to feed self." Medical record review revealed the resident's weight remained stable from admission until weight loss as noted:	F 325	the audits will be reported to the Performance Improvement Committee for review and determination of ongoing compliance. The Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Medical Records Director, Maintenance Director, Social Services Director, Dietary Manager, Housekeeping/ Laundry Director, Activities Director, Business Office Manager, HR Manager, Medical Director and Consultant Pharmacist. F 325 Durham-Hensley Health & Rehabilitation believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions: <u>Corrective Actions for Targeted Residents</u> Resident #53 is currently being monitored by the NAR committee as of 5/28/12. Interventions are currently in place for this resident to aid in prevention of further weight loss. The Registered Dietician's assessment was completed 5/5/12 and recommendations were approved by the MD and implemented. This resident's weights will be reviewed weekly until stable for four weeks.	6/30/12

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F 325	Continued From page 6 Date: 11/10/2011; Weight 162; BMI: 32 Date: 12/22/2011: Weight 158 Date: 01/07/2012: Weight 155 Date: 02/06/2012: Weight 147; BMI: 29 (a weight loss of 5% in one month.) Medical record review revealed Mental Health evaluated the resident on February 7, 2012, for depression, with orders for Trazodone (antidepressant) 25 mg. at bedtime. Medical record review revealed the weight loss was reported to the physician. The resident was assessed by the physician on February 8, 2012, with no new orders addressing the weight loss. Medical record review revealed the resident was placed on weekly weights in February. Review of documents provided by the facility revealed the resident's weight was discussed in the weekly NAR (nutrition at risk) meeting on February 9, 2012, however no new interventions were attempted and there was no documentation the resident was evaluated by the Registered Dietitian (RD) until March 13, 2012, when the weight loss was addressed. Interview with the Director of Nursing (DON) in the DON's office on May 24, 2012, at 2:00 p.m., revealed during the time frame of the resident's weight loss, the facility had hired a new RD. Further interview confirmed no new interventions for this resident's weight loss were attempted from February 6, 2012, until March 13, 2012, causing a delay in treatment.	F 325	Identification of Other Residents with Potential to be Affected Current residents' weights were reviewed by the NAR committee on 6/1/12 and appropriate dietary interventions to prevent weight loss were found to be in place. Systematic Changes Monthly and weekly weights will be reviewed by the NAR committee and the RD. Any resident with a significant weight loss or gain, poor nutritional intake, or high risk for weight loss or gain during the weekly NAR meeting are placed on the NAR program for closer monitoring and placement of dietary interventions. Newly admitted residents are weighed weekly for four weeks. Weights are reviewed weekly by the NAR committee, which includes the DON, RD, ADON, Dietary Manager, and restorative aide. When a weight loss has been identified before the next meeting, the RD will be notified within 72 hours for recommendations. Monitoring The RD will review weekly weights to ensure appropriate dietary interventions are in place. The DON will audit weights weekly for three months to ensure appropriate dietary interventions are in place for weight loss/gain. These audit findings will be reported to the Performance Improvement Committee for review and	

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